

MISSOURI DEPARTMENT OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-036196

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No.

318
FILED OCT 11 1962

Primary Registration District No.

1003

Registrar's No.

9529

STATE FILE NUMBER

VS 300
Rev. 4/59

1

2 220

3

4 2

5 1

6

7 1

8 2

9

10

11

12 77-0

13

77

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		c. CITY OR TOWN St. Louis	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Homer G. Phillips		d. STREET ADDRESS (If outside, give location) 2404 Elliott	
3. NAME OF DECEASED (Type or print) First Middle Last Robert Gray		4. DATE OF DEATH Month Day Year 10 3 62	
5. SEX Male	6. COLOR OR RACE Negro	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 4-15-1908
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Labor		11. BIRTHPLACE (City and state or country) Patterson, Louisiana U.S.A.	
13a. FATHER'S NAME Phillip Gray		14. NAME OF HUSBAND OR WIFE Sarah Gray	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		17. INFORMANT Sarah Gray 2404 Elliott	
18. CAUSE OF DEATH (Enter only one cause per line for PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Generalized Metastasis Adenocarcinoma of the Prostate Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.) DUE TO (b) 177X DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH Undet.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from 9-6-62 to 10-3-62 and last saw him alive on 10-3-62 Death occurred at 8:15 P. m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE B. Phillips M.D.		22b. ADDRESS 2601 N. Whittier	
22c. DATE SIGNED 10-5-62			
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 10-9-1962	23c. NAME OF CEMETERY OR CREMATORY Morgan, Louisiana	
24. FUNERAL DIRECTOR Boyd Funeral Home 3704 Finney		25. DATE RECD. BY LOCAL REG. OCT 5 1962	
		26. REGISTRAR'S SIGNATURE Earl Smith, M.D.	

USE BLACK INK

OR TYPEWRITER RIBBON

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed W. Claude Gordon

Licensed Embalmer No. 3489

P. O. Address 11237 Taylor

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.